

## Hypochondriasis and Depression in Out-patients at a General Hospital

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The aims of this paper are first, to describe some clinical features of patients eventually diagnosed as having a depressive illness who were referred to a general hospital clinic set up to study hypochondriasis, and secondly, to investigate why some patients with depressive disorders develop somatic symptoms while others do not.

Our interest in the hypochondriacal patient with persistent somatic complaints arose from our previous experience in the psychiatric out-patient department of a general hospital. All such departments are familiar with a small, but distinct, group of patients referred to the psychiatrist from other clinics as a last resort after intensive and often prolonged investigations which show no positive physical findings commensurate with the patients' complaints. In many instances the patient will have been seen by a number of specialists, have had elaborate laboratory investigations, diagnostic surgical examinations and courses of special treatment. The patient's suffering, however, is as flagrant at the end of this very expensive odyssey as it was at the start. The cost to the patients as well as to the health service makes the earlier recognition and a more precise description of these problematical patients a matter of general, as well as of psychiatric, interest.

To explore the problem further, the Research Unit set up a clinic at a local general hospital to which we invited the consultant staff to refer any patients with persistent, somatic complaints not adequately accounted for by their clinical investigations, or whom they considered to be hypochondriacs. From the heterogeneous conditions seen at this clinic one distinctive group is described here: cases diagnosed by the psychiatrist as having a depressive illness with pronounced somatic hypochondriacal symptoms. Of the 120 patients referred in the first two

years, 21 clearly fell into this category. All of them had already been fully investigated medically for a prolonged period.

The method used to study the problem of why some patients with depressive illnesses develop somatic symptoms, while others with the same diagnosis do not, was to compare the clinic cases with a control group of 21 patients attending a psychiatric clinic, all of whom had clearly depressive illnesses but with no somatic complaints (finding these subjects proved to be unexpectedly difficult). The control group was constructed by direct pairing with the patient group for age, sex and severity of illness (as indicated by in-patient, as against exclusively out-patient, treatment being required at some point during the study). There were 13 women and 8 men in both groups. The age distribution was 35-44, five in each group; 45-54, seven in each group; 55-64, five "somatizing" patients and six "non-somatizing" controls; 65-74, four patients and three controls.

A number of hypotheses, which will be described later, served to organize and delimit the data collected. To ensure the information was systematically obtained from all the cases an extensive item sheet was completed on every patient. The items in this questionnaire were restricted as far as possible to clinical and social facts which could be enumerated, and to descriptive categories or ratings of behaviour on the definition of which we could agree.

### RESULTS

In the *family histories* of the two groups, we could find no significant differences in the incidence of chronic physical or mental ill health. Nor did they differ in the incidence of parental deprivation, anomalous home situations (e.g. step-parents), age of patient when the

parents died, size of sibship or position in sibship, or in parental personality traits as described by the patient. However, a significantly greater similarity was found between the patients' and their mothers' symptoms in the clinic cases than in the control group. There was no such correspondence with fathers' symptoms (see Table I). There was also some suggestion that the patients viewed their mothers as having had less positive feelings towards them than did the controls: eight of the former as against three of the latter described their mothers' feelings as frankly hostile or ambivalent. Again, no similar trend in their fathers' attitude was observed.

TABLE I  
*Similarity of Main Symptoms to Main Illness of Parents*

				Mother	
				Patients	Controls
Similar†	..	..	..	9	3
No similarity	..	..	..	11	17
Totals..	..	..	..	20*	20*

$$\chi^2=4.29 \text{ (p} < .05 \text{)}$$

† Similar was scored when the subject and the parent had virtually the same syndrome, or had outstanding symptoms in common. Lesser degrees of similarity were discounted.

\* One subject omitted because data were unreliable, or where there was no parental figure.

In *childhood*, a history of admission to hospital, surgical operations or prolonged illness at home was equally common in both groups.

As regards *previous illness*, we found a significantly greater amount of those illnesses commonly accepted as psychosomatic (Sainsbury, 1960) in the patient group. The disparity with the control subjects was especially marked for illnesses beginning in childhood and adolescence, when 12 patients as against only 2 controls had been afflicted in this way.

The amount of general medical and surgical hospital treatment later in life but prior to the present illness was approximately equal in the two groups. Five of the patients and nine of the controls had had previous in-patient or day hospital treatment for psychiatric disorders.

TABLE II  
*Incidence, with Age of Onset, of Psychosomatic Illnesses*

				Patients	Controls
None ..	..	..	..	5	10
Onset before 13th birthday..	7	1	}	21	11
Onset between 13th and 20th birthday ..	5	1			
Onset after 20th birthday ..	9	9			
Totals..	..	..	..	26	21

$$\chi^2=4.31 \text{ d.f.}=1 \text{ (p} < .05 \text{)}$$

The *personal histories* of the two groups were similar in respect to such variables as marital status, educational level, work record, pre-morbid financial status, social activities and the age and health of the spouse. Marital disharmony, however, was much greater among the patients, and their sexual adjustment was also much poorer (see Tables III and IV).

TABLE III  
*Marital Adjustment in Ever-married Subjects (subject's assessment)*

				Patients	Controls
Happy marriage: few problems ..	..	..	..	5	15
Some problems ..	7	1	}	12	2
Unhappy marriage: many problems ..	5	1			
Totals..	..	..	..	17	17

$$\chi^2=8.95 \text{ (p} < .01 \text{)}$$

TABLE IV  
*Sexual Adjustment in Currently-married Subjects*

				Patients	Controls
No evidence of maladjustment				4	11
Subjective and/or objective evidence of maladjustment				10	2
Totals..	..	..	..	14	13

$$\chi^2=6.45 \text{ (p} < .02 \text{)}$$

In the *premorbid personalities* of the patients we had expected to find a greater concern with various "health fads", e.g. special diet, regular aperients, than in the controls, but this was not

so. They were described as habitually anxious and worried people much *less* often than were the control group (4 in the former compared with 12 in the latter).

We may now turn to the *history of the illness* for which the patient was referred to us, and would first like to stress how very chronic these were. Half the patients had been ill for over 10 years, and one had been continuously ill for 30 years. The patients' illnesses, by their own account, were invariably unremitting; only one patient reported freedom from symptoms for as long as one week. During the course of the illness, about half the patients had been admitted to a general hospital, two of them more than 6 times. About a third had had surgical operations, and two had had four such interventions. The current illnesses of the control group were very much shorter, all less than one year, but the difference disappeared on comparing the age at first attack in the two groups. Unlike the clinic patients, they commonly showed the intermittent course usually associated with depressive illness. Other aspects of the history will be mentioned in the discussion. There was a significantly greater number of conspicuous environmental events coincident with the onset of the present illness in the patients than the controls (11 compared with 4). They included *inter alia* operations or in-patient investigations in 4, death in the family in 3, illness in the family, retirement and the 60th birthday (1 each). Likewise clearly aggravating and clearly ameliorating factors were both given significantly more often by the patients than the controls (see Table V). The aggravating factors cited by the patients included illnesses in the

family, especially if nursing attention was required (2 cases), the death of a neighbour (1) and emigration of a son (1); domestic conflicts (3); occupational stresses (2); menstruation (2); multiple causes (5); while a more unusual group included taking aperients, drinking liquids, and horse-riding (1 each). The ameliorating factors all related to relaxation, diversion, holidays, etc. The patients' illnesses were thus more "reactive" than were the controls. It is also interesting that we found the patients' illnesses disrupted their social activities, work or family relationships significantly less often than did the illnesses in the control group (see Table VI).

On *mental state examination*, further differences emerged. As might be expected the patients were often hostile to seeing a psychiatrist, and nearly all proffered a physical explanation of their symptoms: this was true of none of the controls. The most important (significant) differences relate to affect and mood. The patients felt less anxious and displayed less agitation than the control group. They also showed less depressive affect, but the degree of subjective depression elicited by questioning was in fact the same in both groups (see Table VII). It may well be that it is the covert nature of the affective change which results in these patients remaining undiagnosed for so long in the general hospital.

Other points worth noting about the patients were that we saw no examples of *belle indifférence* in either group, and there was no difference in cognitive function nor estimated intelligence. Obsessional features were not prominent in this particular sample.

The commonest sites of major distress were

TABLE V  
*Environmental Effects on Severity of Symptoms*

						Aggravating effects		Alleviating effects	
						Patients	Controls	Patients	Controls
None: minor	..	..	..	..	4	15	14	21	
Marked	..	..	..	..	16	6	6	0	
Totals	..	..	..	..	20*	21	20*	21	

\* One patient omitted as data unreliable.

$\chi^2=11.16$  ( $p<.001$ )

$\chi^2=5.17$  ( $p<.05$ )

TABLE VI  
*Disruptive Effect of Symptoms*

				Effect on Social Activities		Effect on Occupation		Effect on Family Life	
				Patients	Controls	Patients	Controls	Patients	Controls
None: minor	..	..	..	14	2	13	4	13	4
Marked	..	..	..	7	19	8	16	8	16
Totals	..	..	..	21	21	21	20*	21	20*
				$\chi^2=14.54$ ( $p<.001$ )		$\chi^2=7.41$ ( $p<.01$ )		$\chi^2=7.41$ ( $p<.01$ )	

\* Subject omitted because not normally employed and had no family.

TABLE VII  
*Incidence of Anxiety and Depression, and their Affects*

1. Anxiety									
						Anxious mood		Agitation, tension	
						Patients	Controls	Patients	Controls
None or minimal	..	..	..	..	..	14	6	18	7
Marked	..	..	..	..	..	7	15	3	14
Totals	..	..	..	..	..	21	21	21	21
						$\chi^2=6.11$ ( $p<.02$ )		$\chi^2=4.86$ ( $p<.05$ )	
2. Depression									
						Depressive mood		Depressive affect	
						Patients	Controls	Patients	Controls
None or minimal	..	..	..	..	..	11	8	19	10
Marked	..	..	..	..	..	10	13	2	11
Totals	..	..	..	..	..	21	21	21	21
						$\chi^2=0.86$ N.S.		$\chi^2=9.02$ ( $p<.01$ )	

the head, abdomen and chest, much more commonly experienced in the front of the body than behind, but with no appreciable difference between the right and left sides. Somatic complaints were commonest in the alimentary and muscular-skeletal systems. Five patients had frequently changing complaints but the majority kept to a fairly standard repertoire, usually involving a number of physiological systems.

Observations on phenomenology and social

background are given after the following discussion of these data.

#### DISCUSSION

It is worth repeating that the kind of patient with whom we are here concerned is not the familiar mental hospital in-patient with an obvious depressive illness which includes prominent hypochondriacal features, but the patient

referred only after prolonged specialist investigation or treatment along general medical lines has been unavailing. The fact that about a quarter of the patients had had an overt psychiatric illness in the past did little to expedite their referral. Probably the main reason for the failure to make the diagnosis is that the possibility of a depressive illness is not borne in mind. Even if it is considered, the camouflaged form of the disorder is insufficiently recognized, and the lack of any outward display of altered mood, other than excessive concern about physical symptoms, is taken as evidence against a depressive illness. Following the patient's lead, the physician is apt to accept the physical symptoms as pointers to an obscure somatic disease, and the depressed mood, loss of energy and interest, or exhaustion, as secondary effects. A second reason for delayed referral might be that prolonged scrutiny sometimes reveals minor somatic abnormalities which the importunity of the patient encourages the physician to continue to investigate in spite of equivocal findings.

The interpretation of our results hinges largely on the assumption that our group of hospital attenders had atypical depressive illnesses. Our cardinal guides were the presence of an affective change experienced by the patient as depressive mood or listlessness, loss of energy, early morning waking or diurnal variation (many of these features were presented as attributes of physical illness); a persisting apprehension or conviction of illness or of impending death and dissolution; gloomy fears about the future; and to some degree, a beneficial response specifically to anti-depressant therapy. In confirmation of our diagnosis we may point to the similar incidence of family illness in the two groups, and the similar age when the first episode of illness occurred. The data on reactive features among the patients suggest we are often dealing with the form of affective disorder in which exogenous factors are conspicuous, and it is interesting to note that in their recent factor-analytic study of symptoms in affective disorders Kiloh and Garside (1963) found hypochondriasis to be weighted more heavily with the "reactive" than "endogenous" factor. This finding also suggests that in a study of the kind of patient we are

discussing, the most sensitive controls would be subjects suffering from reactive depression.

We failed to substantiate the view that frequent admission to hospital or prolonged illness in childhood conduced to a hypochondriacal illness later in life, since no difference could be demonstrated between the two groups in the amount of medical attention they received as children.

The relative infrequency with which the patients' personalities, as compared with the controls', were described as habitually anxious was an unexpected finding, and one we have difficulty in evaluating.

The chronicity of illness in patients with psychogenic pain, especially the depressive group, has been noted by other workers: Bradley (1963) describes illnesses of up to 16 years, and many of our cases had been ill for even longer. This protracted course occurred in our cases in association with any somatic symptom and not only with pain. The relationship between the original symptom and the onset of subjective depression is very difficult to elucidate. It was common to find in these long-standing cases that the depressive *mood change* became evident only after several years from the onset of the illness. There are at least two possible explanations. First, one may consider that the symptom represents a kind of "depressive equivalent", and that the covert psychological aspects become manifest only with the later evolution of the illness. If this were so, then a treatment which effectively cleared up the depression should do the same for the somatic symptoms. In fact it was rare for a *total* remission of this kind to be obtained: patients would declare themselves "99 per cent. better"; or would lose their depression and, say, their chronic nasal catarrh, but still have some weakness of the hips; or would even profess themselves well in all respects and optimistic about the future provided they took special care of their supposedly ailing member. We often had the impression that the patient no longer felt himself to be ill but could not believe he was well. It may be that, either because of strength of habit or because the patient's self-concept of himself as sick serves some further psychological need, it is difficult for him after

treatment to view himself as quite healthy (which means, of course, that he is not).

An alternative view is that there are two basic processes at work, one being responsible for the primary somatic symptom and the second being a reactive depression following chronic disability. During the depressive phase all the initial symptoms seem much worse, as is commonly found when a depressive illness complicates any other kind of illness. Treatment of the depression might on this theory be expected to restore the patient at least to his pre-depressive level of tolerance and function, but no more. Such a hypothesis is unsatisfactory in many ways: it leaves unspecified the nature of the original pathology; it conflicts with evidence concerning the kind of depressive illness which might develop (Bradley, *op. cit.*); and it requires further postulates to explain why so many patients achieve a nearly complete remission of all their symptoms, if only temporarily. Nevertheless, it is almost impossible to refute conclusively, and perhaps if the original process is conceived in psychological terms, the two theories are not so very different after all.

Mention has been made of precipitating factors, and it will be recalled that quite often these apparently consisted of medical procedures. It is difficult to be certain just how often the latter can be incriminated as true precipitants, since on some occasions at least the operations or other investigations were directed at already existing psychogenic symptoms. It is evident that a patient should not be denied appropriate investigation of any kind if it will clarify the diagnosis. Nevertheless, physical investigations undoubtedly gave powerful reinforcement to the patients' fears or beliefs in a substantial proportion of cases, and often helped to localize and perpetuate a previously nebulous and perhaps transitory concern. Moreover, it is by no means obvious that psychiatric appraisal at this early stage would have revealed any abnormal features. This does not, of course, mean that there is no need to consider the patient's mental state and the possible consequences that special investigations may have. In our experience, however, it is not the actual procedure which does the psychological harm so much as the way in which

it is explained to the patient. Admittedly there is a kind of patient whose psychological needs preclude him from accepting, or even hearing, what his doctor has said. But with many of our patients there seems to have been little attempt to tell the patient and his family why a test was necessary or, more importantly, what conclusions were drawn from it. In predisposed subjects the outcome of such omissions has been a potent iatrogenic component of the patient's illness. In view of the difficulty of recognizing in advance such potentially vulnerable cases, the only practical procedure is the prophylactic one of a clear explanation to every patient submitted to special tests, in terms which he can understand, and given by the person who initiates the investigation. Our findings regarding the importance of iatrogenic and environmental influences on the course of the illness confirm those of Katzenelbogen (1942) and Leonhard (1961).

It seems to us that the distribution of body sites at which the somatic symptoms (when localized) were experienced reflect the relative importance of these areas in the body-image rather than the cerebral cortical representation of the soma.

#### PHENOMENOLOGY

We would like to comment briefly on two aspects of the phenomenology of somatic complaint in our patients. The first point concerns what the patient believes to be wrong with him. It is often possible to distinguish the recurrent, "absurd" doubts of the obsessional patient from the more settled and pessimistic beliefs of the depressive. Within the latter group, however, with which we are primarily concerned here, we do not find it possible to distinguish between depressive delusional beliefs and fears that something is wrong. A similar conclusion was reached by Brown (1936). The patient is undoubtedly concerned about his symptoms, but often cannot produce any interpretation of them beyond the statement that something either *is* or *might be* amiss. The note of conviction with which a "psychotically depressed" patient declares that his bowels are obstructed was not often heard in this series.

There are many questions here which might repay closer scrutiny.

Secondly, we have been struck by how frequently the patient expresses in the hypochondriacal complaint not only anxiety but also some degree of satisfaction. In his depressed mood, he relates his history and an account of his current activities in tones of gloomy disenchantment and apathy. His voice only displays any warmth or vitality when he is allowed to launch into the details of his supposed somatic disabilities, describing his ailing part with a loving concern, or at least a lively interest, strikingly lacking from the rest of his world. This observation perhaps furnishes a clue to the psychodynamics of somatic complaints, which we hope to elaborate in another report.

#### FURTHER AETIOLOGICAL CONSIDERATIONS

Any of the differences already noted between our two groups might help clarify the problem of why some patients with a depressive illness develop somatic symptoms while others do not. However, before commencing this study we set up four hypotheses which might now be considered. The first of these postulated that somatic symptoms are used by the socially isolated individual to promote social interaction with medical personnel, using what the patient believes to be acceptable medical language, i.e. that of bodily ill-health. From this it follows that there should be a higher proportion of "somatizers" who were socially isolated, which was operationally defined as being unmarried or living in small rather than extended family groups. We found no evidence to support this hypothesis. Nevertheless, on clinical grounds, it seemed quite evident that in a few cases some such mechanism was undoubtedly operating. For these patients the statement "I am ill" seemingly means "I am lonely".

The second hypothesis was that somatic symptoms reflect culturally and familially determined attitudes as to what constitutes illness. It was postulated that since awareness and acceptance of psychological illness reflect some degree of sophistication there would be an excess of lower social class and of the less educated among the "somatizers" (Hollingshead

and Redlich, 1958). We did indeed find a trend in this direction but one not sufficient to reach statistical significance. We also postulated that somatizing patients would have families of origin in which much importance had been attached to physical symptoms, but such data as we were able to elicit on this point failed to substantiate this view: the total experience of physical illness in the families of patients and controls was much the same. But we found that the clinic patients showed a greater resemblance to their mothers in respect of their "choice" of somatic symptoms than to their fathers, and also differed in the former respect from the controls. This suggests that they tended to use their mothers' illnesses, when present, as a model for their own. Some support for this view is provided by Apley and MacKeith (1962) who noted that children with recurrent functional pains were commonly copying their symptoms from another family member, notably the mother. We found no tendency to use as a model any symptoms the spouse might have, and a quest for other significant figures was not convincingly successful. We are aware of the widespread belief that hypochondriacal patients commonly are anxious about themselves in a manner determined by some striking illness in a member of their current entourage, but such a mechanism, though demonstrable in some individuals, does not seem to be very general. The identification with the sick mother is presumably formed early in life and often long before the development of an overt illness in the patient. For these, "I am ill" might signify, in addition to other meanings, "I am in some kind of distress, but have learned no language other than my body by which to convey this."

The third hypothesis was that depressive patients with somatic complaints would have a greater tendency to develop psychosomatic disorders. This was confirmed when we found that a history of classical psychosomatic illness was twice as common in the clinic patients as in the controls: this discrepancy was demonstrable only for illnesses beginning before the age of twenty.

The last hypothesis focused on the patient's interpersonal relations, especially as reflected in marriage. Since a somatic symptom can often

elicit attention and concern on the part of a spouse and could therefore be used as a neurotic control mechanism where a psychological symptom could not, we predicted that the "somatizing" patients would have poorer marital relationships than the controls. This hypothesis was supported by the data and seems worthy of further study, even though alternative explanations of our findings are possible. It was striking how often the patients would start to describe their spouses' personality with the phrase "He's good to me when I'm ill."

#### MANAGEMENT AND TREATMENT

Many psychiatric patients who feel physically ill are unenthusiastic about being referred to a psychiatrist. Where, as in this series, the patient's basic concern is that he has an undiagnosed somatic pathology, the reluctance may sharpen into frank hostility. Nevertheless, further progress will often go smoothly once the patient is convinced of his new therapist's interest: indeed, the recognition by the psychiatrist that the patient is in a state of psychological distress—quite apart from questions of physical illness—is often accepted with great relief. We feel it important that the psychiatrist conveys that he recognizes the importance of the symptoms to the patient. Reassurance regarding physical health was given when it was requested by the patient—and sometimes it was asked for at considerable length—but we found it unwise to press reassurance otherwise. Indeed, we learned that over-emphatic statements to the patient that he was physically quite well could sometimes lead to a state of psychological hypochondriasis in which somatic fears were replaced by fears of insanity. For the majority of cases, questions about the origin of the physical symptoms soon assumed a minor role in discussion: for a minority, psychophysiological explanations where appropriate, e.g. increased muscle tension, impaired motility, seemed to be very acceptable. In no case did the therapist wittingly connive with the patient's views of somatic aetiology, but generally, once having made his own view clear, the therapist did not repeat it with too much zeal: the extent to which psychological interpretations were

given varied with the type of patient and the therapeutic plan.

The main lines of treatment were, of course, those of the depressive illness. As previously noted, environmental influences on the illness were often elicited, and these could sometimes be manipulated therapeutically. The role played by the hypochondriacal symptoms in the patient's relationships, especially with the spouse, was often profitably explored in a psychotherapeutic setting with the patient, or by social casework, or both.

#### TREATMENT

We are unable to offer any objective evidence regarding the therapeutic outcome of the patient group. In general our experience confirms the usual view that depression with hypochondriasis is more difficult to treat than uncomplicated depression. Nevertheless, we have been impressed by the response to antidepressant drugs, E.C.T. or psychotherapy of some seemingly intractable patients, from whose histories little improvement would have been expected. Of our 21 patients, 6 made good recoveries and were subsequently discharged. A further 9 made moderate gains on long-term treatment, while the remaining 6 have shown little progress.

#### SUMMARY

1. Some clinical features of patients with depressive disorders referred to a special hypochondriasis clinic after prolonged general medical investigation are briefly described. Twenty-one such patients were compared with a matched control group of patients with the same diagnosis but with no somatic symptoms, and the differences between the groups analysed in an attempt to ascertain the factors responsible for the "somatizing" process.

2. Four hypotheses were tested. It was postulated that the hypochondriacal patients would show, (i) a higher degree of social isolation, (ii) a lower socio-economic status, and families of origin in which much importance was attached to physical illness, (iii) a greater likelihood of psychosomatic disorders, (iv) poorer interpersonal relationships, especially in marriage. The first two hypotheses were not



substantiated, though the mechanisms implied appeared operative in some individuals. The other hypotheses were confirmed.

3. The remaining (statistically significant) differences between the "somatizing" and "non-somatizing" patients were that the former showed (a) a greater similarity between their pattern of symptoms and those of their mothers': this was not true for fathers; (b) poorer marriage relationships and sexual adjustment; (c) a greater likelihood for the current illness to be precipitated by stressful external events, often relating to death or illness, and to fluctuate markedly with environmental change; (d) a much greater chronicity of the present illness; (e) less disruption of social, family and occupational activities; (f) a relative lack of depressive affect, despite an equal intensity of depressive mood, and less evidence of subjective or objective anxiety.

4. Some observations on the phenomenology of hypochondriasis are presented.

5. Some comments are offered on the prophylaxis, management and treatment of hypochondriacal depression.

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(Received 9 November. 1964)

# BJPpsych

The British Journal of Psychiatry

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*BJP* 1965, 111:607-615.

Access the most recent version at DOI: [10.1192/bjp.111.476.607](https://doi.org/10.1192/bjp.111.476.607)

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